Company Tracking #: 12-82-049(F)(REV)

State: Arkansas Filing Company: Colonial Penn Life Insurance Company

TOI/Sub-TOI: L07I Individual Life - Whole/L07I.111 Single Premium - Single Life

Product Name: Individual Life Insurance

Project Name/Number: /

Filing at a Glance

Company: Colonial Penn Life Insurance Company

Product Name: Individual Life Insurance

State: Arkansas

TOI: L07I Individual Life - Whole

Sub-TOI: L07I.111 Single Premium - Single Life

Filing Type: Form

Date Submitted: 09/20/2012

SERFF Tr Num: BNLC-128694484

SERFF Status: Closed-Approved-Closed

State Tr Num:

State Status: Approved-Closed
Co Tr Num: 12-82-049(F)(REV)

Implementation 01/01/2013

Date Requested:

Author(s): Wilbur Henderson Reviewer(s): Linda Bird (primary)

Disposition Date: 09/26/2012

Disposition Status: Approved-Closed

Implementation Date:

State Filing Description:

SERFF Tracking #: BNLC-128694484 State Tracking #: Company Tracking #: 12-82-049(F)(REV)

State: Arkansas Filing Company: Colonial Penn Life Insurance Company

TOI/Sub-TOI: L07I Individual Life - Whole/L07I.111 Single Premium - Single Life

Product Name: Individual Life Insurance

Project Name/Number: /

General Information

Project Name: Status of Filing in Domicile: Authorized
Project Number: Date Approved in Domicile: 09/12/2012

Requested Filing Mode: Informational Domicile Status Comments: Explanation for Combination/Other: Market Type: Individual Submission Type: New Submission Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 09/26/2012

State Status Changed: 09/26/2012

Deemer Date:

Created By: Wilbur Henderson

Submitted By: Wilbur Henderson Corresponding Filing Tracking Number: 12-82-049(F)(REV)

Filing Description:

RE: Individual Life Insurance

12-82-049(F)(REV) Application 12-82-050(F)(REV) Application 12-82-055(REV) Application 12-82-056(REV) Application 12-82-057(REV) Application 12-82-058(REV) Application

NAIC# 233-62065 FEIN# 23-1628836

Dear Mr./MS:

Attached for your review and approval are copies of the above captioned forms. These forms are new and will replace corresponding forms currently on file with your Department.

These forms were previously approved by your Department. The only change to these new forms is the mandated MIB,Inc language change in the authorization section at the end of the second paragraph, which reads, "I authorize the Company, or its reinsurer, to make a brief report of my personal health information to MIB". This change is effective 1/1/13. No other changes have been made to the applications. Coverage will continue to be marketed on a direct response simplified issue basis.

To assist with submission, below are the previously approved applications with approval information:

Application Approval Date SERFF Trk # State Trk #

12-82-049(F) 8/26/10(all) BNLC-126676280 (all) 46598 (all)

12-82-050(F)

12-82-055

12-82-056

12-82-057

12-82-058

SERFF Tracking #: BNLC-128694484 State Tracking #: Company Tracking #: 12-82-049(F)(REV)

State: Arkansas Filing Company: Colonial Penn Life Insurance Company

TOI/Sub-TOI: L07I Individual Life - Whole/L07I.111 Single Premium - Single Life

Product Name: Individual Life Insurance

Project Name/Number: /

We have also included an Officer's Certification acknowledging no other changes to these forms. These new forms upon approval effective 1/1/13 will continue to be with previously approved policy forms currently on file with your Department. Should you need additional information, do not hesitate to contact me.

Wilbur Henderson Jr

Company and Contact

Filing Contact Information

Wilbur Henderson Jr., Contract Analyst whenderson@colpenn.com 399 Market Street 215-928-6085 [Phone] Philadelphia, PA 19181 215-928-6431 [FAX]

Filing Company Information

Colonial Penn Life Insurance CoCode: 62065 State of Domicile: Company Group Code: 233 Pennsylvania

399 Market Street Group Name: Company Type: Life/Health

Philadelphia, PA 19181 FEIN Number: 23-1628836 State ID Number:

(215) 928-8688 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$300.00

Retaliatory? No

Fee Explanation: \$50.00 per form (6)

Per Company: No

CompanyAmountDate ProcessedTransaction #Colonial Penn Life Insurance Company\$300.0009/20/201262880579

SERFF Tracking #: BNLC-128694484 State Tracking #: 12-82-049(F)(REV)

State: Arkansas Filing Company: Colonial Penn Life Insurance Company

TOI/Sub-TOI: L07I Individual Life - Whole/L07I.111 Single Premium - Single Life

Product Name: Individual Life Insurance

Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/26/2012	09/26/2012

 SERFF Tracking #:
 BNLC-128694484
 State Tracking #:
 Company Tracking #:
 12-82-049(F)(REV)

State: Arkansas Filing Company: Colonial Penn Life Insurance Company

TOI/Sub-TOI: L07I Individual Life - Whole/L07I.111 Single Premium - Single Life

Product Name: Individual Life Insurance

Project Name/Number: /

Disposition

Disposition Date: 09/26/2012

Implementation Date: Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access		
Supporting Document	Flesch Certification		Yes		
Supporting Document	Application		Yes		
Supporting Document	Life & Annuity - Acturial Memo		No		
Supporting Document	Officers Certification		Yes		
Supporting Document	Copy of Approval		Yes		
Form	Application		Yes		
Form	Application		Yes		
Form	Application		Yes		
Form	Application		Yes		
Form	Application		Yes		
Form	Application		Yes		

SERFF Tracking #: BNLC-128694484 State Tracking #: 12-82-049(F)(REV)

State: Arkansas Filing Company: Colonial Penn Life Insurance Company

TOI/Sub-TOI: L07I Individual Life - Whole/L07I.111 Single Premium - Single Life

Product Name: Individual Life Insurance

Project Name/Number: /

Form Schedule

Lead	Lead Form Number: 12-82-049(F)(REV)								
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments		
1		12-82- 049(F)(REV)	AEF	Application	Initial:	57.200	12-82-049(F)(REV).pdf		
2		12-82- 050(F)(REV)	AEF	Application	Initial:	57.200	12-82-050(F).pdf		
3		12-82- 055(REV)	AEF	Application	Initial:	57.200	CPL_EM055.pdf		
4		12-82- 056(REV)	AEF	Application	Initial:	57.200	CPL_EM056.pdf		
5		12-82- 057(REV)	AEF	Application	Initial:	57.200	CPL_EM057 (2).pdf		
6		12-82- 058(REV)	AEF	Application	Initial:	57.200	CPL_EM058.pdf		

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
отн	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

COLONIAL PENN LIFE INSURANCE COMPANY, Philadelphia, PA 19181 SIMPLIFIED ISSUE APPLICATION for

Proposed Insured _[John Doe]	Area Code/Phone # - Day [000-000-0000]
	Area Code/Phone # - Evening [000 - 000 - 0000]
Address [123 Main St.]	E-Mail Address [XXXXXXXXXXXXXXXXXX]
City [Anytown] ST [OH] ZIP [00000-0	$\frac{000]}{\text{Age }[x]} \text{Date of Birth} \underline{[00/00/0000]} \text{ Sex } \underline{[x]}$
Please check ✓ your desired insurance protection and payment Amount of Life Insurance: □ \$0,000 □ \$0,000 □ \$00,000 Initial Premium Enclosed: □ Monthly □ Annual	•
premiums, including past due amounts, to my bank account on or	I authorize Colonial Penn Life Insurance Company to charge my insurance after the day I have selected below. I understand that if a draft on my bank omit the draft again within a week. This authorization is to remain in effect until
Payor's Signature X(As Name Appears on Bank Acco	unt) Premium Deduction Date (3rd to 28th Day of the Month)
1. Statement of Health — Your answers to the questions below questions "Yes" or "No." If "Yes" c	help determine your eligibility for this coverage. Answer each of the ircle the condition(s) which apply. Additional information may be necessary.
a walker, wheelchair or motorized mobility device; (3) using s facility, or correctional institution?	perform your daily activities such as dressing, eating or walking; (2) using supplemental oxygen; (4) confined to a hospital, assisted care or nursing
C. In the past three years, have you had, been diagnosed by a member pulmonary disease (COPD), emphysema or chronic bronchitis; (3) chronic kidney disease (not including kidney stones); (4) heard (5) thrombosis or embolism (blood clots)?	of the medical profession with, or received treatment for (1) chronic obstructive (2) chronic liver disease (including chronic hepatitis), cirrhosis of the liver; tattack (myocardial infarction), cardiac arrhythmia, or congestive heart failure;
ischemic attack (TIA), or heart or blood vessel surgery; (2) deme (4) cancer (not including basal cell skin cancer); (5) AIDS (Acquired Virus), or other immune system disorder; (6) mental or nervous was recommended or completed; (7) alcohol or drug abuse, or ha	r of the medical profession with, or received treatment for (1) stroke, transient ntia, Alzheimer's disease, or ALS (amyotrophic lateral sclerosis); (3) diabetes; d Immunodeficiency Syndrome), infection with HIV (Human Immunodeficiency system disorder for which inpatient treatment or confinement in an institution as treatment been recommended?
E. Physician	Address Area Code and Phone No.
2. Beneficiary Designation (will be divided equally unless noted of	
A	B. Beneficiary Name (Please Print) Relationship to You % Share
3. Is this insurance intended to replace or change any existing life in	surance or annuity plan?
Name of Insurance Company Plan of	Insurance Amount of Insurance
of any policy issued and that, within the contestable period, a false sor to deny a claim. I understand and agree that no life insurance is i	my knowledge and belief. I understand that this application shall form a part statement or answer can be used to contest the policy as of its effective date n effect as a result of this application unless this application is approved by continued insurability, according to medical information provided in effective on the Policy Date shown on the Policy Schedule.
MIB, Inc., or any other organization, institution or person, that has a Insurance Company and its underwriters or reinsurers any such infor for this insurance. A reproduction of this authorization shall be as valid the date signed. I understand that upon request, I or an authorized re	clinic or other medical or medically related facility, insurance company, or any records or knowledge of me or my health, to give to Colonial Penn Life mation. I understand such information will be used to determine my eligibility d as the original. The authorization will be valid for a period of 24 months from presentative have a right to receive a copy of this authorization. I authorize the lth information to MIB. I have received and read the Notice to Applicant.
Any person who knowingly presents a false or fraudulent claim for application for insurance is guilty of a crime and may be subject to fin	payment of a loss or benefit or knowingly presents false information in an les and confinement in prison.
Signature of Proposed Insured X	Date:
	Signature/Do Not Print)

12-82-050(F)	.qxd:11-82-050(F).qxd	8/1/12	3:40 PM	F

COLONIAL	PENN	LIFE	INSURANCE	COMPANY,	Philadelphia,	PA	19181
APPLICATI	ON for						

Proposed Insured[John Doe] Address[123 Main St.] City[Anytown]	000 🗆 \$00,000 🗆 \$00,000 🗆 \$00,000
Check here of for Monthly Automatic Bank Deduction and sign below. Your initial premium check will give us all the information we need. I authorize premiums, including past due amounts, to my bank account on or after the day account fails due to insufficient available funds, Colonial Penn will submit the draft I inform Colonial Penn otherwise and allow reasonable time to cancel this paymer	Colonial Penn Life Insurance Company to charge my insurance I have selected below. I understand that if a draft on my bank again within a week. This authorization is to remain in effect until
Payor's Signature X (As Name Appears on Bank Account)	Premium Deduction Date
(As Name Appears on Bank Account) 1. Statement of Health — Answer each of the following questions "Yes" or	
 A. Are you currently: (1) using assistance from another person to perform you a walker, wheelchair or motorized mobility device; (3) using supplemental facility, or correctional institution? B. Have you been advised to have in-patient surgery which has not yet been performed. C. In the past three years, have you had, been diagnosed by a member of the medical pulmonary disease (COPD), emphysema or chronic bronchitis; (2) chronic I (3) chronic kidney disease (not including kidney stones); (4) heart attack (myor (5) thrombosis or embolism (blood clots)? 	r daily activities such as dressing, eating or walking; (2) using oxygen; (4) confined to a hospital, assisted care or nursing Yes \ No ormed? Yes \ No all profession with, or received treatment for (1) chronic obstructive ver disease (including chronic hepatitis), cirrhosis of the liver; cardial infarction), cardiac arrhythmia, or congestive heart failure; Yes \ No
 D. In the past five years, have you had, been diagnosed by a member of the medic ischemic attack (TIA), or heart or blood vessel surgery; (2) dementia, Alzheime (4) cancer (not including basal cell skin cancer); (5) AIDS (Acquired Immunodeff Virus), or other immune system disorder; (6) mental or nervous system disorders was recommended or completed; (7) alcohol or drug abuse, or has treatment be Physician Name 	al profession with, or received treatment for (1) stroke, transient er's disease, or ALS (amyotrophic lateral sclerosis); (3) diabetes; ciency Syndrome), infection with HIV (Human Immunodeficiency ler for which inpatient treatment or confinement in an institution een recommended?
2. Beneficiary Designation (will be divided equally unless noted otherwise)	
A	iciary Name (Please Print) Relationship to You % Share
Name of Insurance Company I have read the questions and my answers are true to the best of my knowledge of any policy issued and that, within the contestable period, a false statement or or to deny a claim. I understand and agree that no life insurance is in effect as a the Company and a policy is issued during my lifetime and my continued this application. In addition, no life insurance or, if elected, additional accidenta has been paid. The life insurance benefit will be effective on the Policy Date show protection, the accidental death benefit will be effective on the Rider Effective Date s I authorize any licensed physician, medical practitioner, hospital, clinic or othe MIB, Inc., or any other organization, institution or person, that has any records consurance Company and its underwriters or reinsurers any such information. I under this insurance. A reproduction of this authorization shall be as valid as the origin the date signed. I understand that upon request, I or an authorized representative in Company, or its reinsurers, to make a brief report of my personal health informatio. Any person who knowingly presents a false or fraudulent claim for payment of application for insurance is guilty of a crime and may be subject to fines and confirmation for insurance is guilty of a crime and may be subject to fines and confirmation.	Amount of Insurance e and belief. I understand that this application shall form a part answer can be used to contest the policy as of its effective date result of this application unless this application is approved by insurability, according to medical information provided in I death protection, is in effect unless the appropriate premium n on the Policy Schedule. If I elected additional accidental death shown on the rider attached to the policy. In medical or medically related facility, insurance company, or or knowledge of me or my health, to give to Colonial Penn Life erstand such information will be used to determine my eligibility al. The authorization will be valid for a period of 24 months from have a right to receive a copy of this authorization. I authorize the hat on the life is a part of the policy. I all the policy is approved by insurance company, or or knowledge of me or my health, to give to Colonial Penn Life erstand such information will be used to determine my eligibility al. The authorization will be valid for a period of 24 months from have a right to receive a copy of this authorization. I authorize the hat of life is approved by have received and read the Notice to Applicant. I all oss or benefit or knowingly presents false information in an
Signature of Proposed Insured X	Date:
(Your Legal Signature/Do No	

12-82-050(F) (REV)

- 1. Please review and complete this form. If you make changes, please make them on both copies and initial your changes. Be sure to sign and date both copies and return one copy to us. Attach the other copy to your Policy.
- 2. Make a check or money order payable to Colonial Penn Life for the amount shown on your premium notice. If you are paying by credit card, we will automatically charge your premium to your credit card.

Questions? Call us Toll-Free #	/////////////////////////////////////	ance
APPLICATION For ###################################		Source Code: ####################################
Colonial Penn Life Insurance Company, Philade	lphia, PA 19181	######################################
Proposed Insured	E-Mail Address: !!!!!!!!!	
######################################	Date of Birth: ######	////
######################################		Sex: ######
######################################	Age: ##	Sex: ######
Area Code/Phone: ####################################	Area Code/Phone:	
Amount of Life Insurance: ####################################	Amount of premium pays	ment: ####################################
1. Statement of Health Answer each of the following		
condition(s) which apply.		
A. Are you currently: (1) using assistance from anoth	er person to perform you	r daily activities
such as dressing, eating or walking; (2) using a vector device; (3) using supplemental oxygen; (4) confine	valker, wheelchair or mo	torized mobility
facility, or correctional institution?	eu to a nospital, assisteu	() Yes (X) No
B. Have you been advised to have in-patient surgery w	hich has not yet been perf	3 (3 _ 1 _ 1 _ 1 _ 1 _ 1 _ 1 _ 1 _ 1 _
C. In the past three years, have you had, been diagnos	ed by a member of the me	edical profession
with, or received treatment for (1) chronic of emphysema or chronic bronchitis; (2) chronic lives	obstructive pulmonary d	isease (COPD),
cirrhosis of the liver; (3) chronic kidney disease	ver disease (iliciddlig cii (not including kidney st	ones): (4) heart
attack (myocardial infarction), cardiac arrhythmia,	or congestive heart failure	e; (5) thrombosis
or embolism (blood clots)?	-	() Yes (X) No
D. In the past five years, have you had, been diagnose with, or received treatment for (1) stroke, transient	ed by a member of the me	edical profession
vessel surgery; (2) dementia, Alzheimer's disease, o		
diabetes; (4) cancer (not including basal cell	ll skin cancer); (5) A	AIDS (Acquired
Immunodeficiency Syndrome), infection with HIV	√ (Human Immunodefici	ency Virus), or
other immune system disorder; (6) mental or ner	vous system disorder for	which inpatient
treatment or confinement in an institution was reduced abuse, or has treatment been recommended?	commended of completed	() Yes (X) No
E. Physician's Name (Please Print)	Pho	
Physician's Address	_	
2. Beneficiary Designation (will be divided equally u		
Box 5 from Name (Name Bird) But for him W. (2001)		<u> </u>
Beneficiary Name (Please Print) Relationship to You % Share		rint) Relationship to You % Share
3. Is this insurance intended to replace or change any of	existing life insurance or a	nnuity plan? () Yes (X) No
Name of Insurance Company Plan of Insura		Amount of Insurance
I have read the questions and my answers are true to application shall form a part of any policy issued an		
answer can be used to contest the policy as of its effective and the contest the policy as of its effective and the contest the policy as of its effective and the contest the policy as of its effective and the contest the policy as of its effective and the contest the policy as of its effective and the contest the policy as of its effective and the contest the policy as of its effective and the contest the policy as of its effective and the contest the policy as of its effective and the contest the policy as of its effective and the contest the policy as of its effective and the contest the policy as of its effective and the contest the policy as of its effective and the contest the policy as of its effective and the contest the policy as of its effective and the contest the policy as of its effective and the contest the policy as of its effective and the contest the policy as of its effective and the contest the policy and the contest the policy and the contest the contest the contest the contest the policy and the contest the con		
no life insurance is in effect as a result of this applic	ation unless this applicat	ion is approved by the Company,
a policy is issued during my lifetime and my continue		
in this application, and the premium has been paid. To Policy Schedule.	ne policy will be effective	on the Policy Date snown on the
I authorize any licensed physician, medical practition	ner, hospital, clinic or ot	her medical or medically related
facility, insurance company, or MIB, Inc., or any other	organization, institution	or person, that has any records or
knowledge of me or my health, to give to Colonia reinsurers any such information. I understand such in		
insurance. A reproduction of this authorization shall		
for a period of 24 months from the date signed.	I understand that up	on request, I or an authorized
representative have a right to receive a copy of this at make a brief report of my personal health information	to MIR I have received	ne Company, or its reinsurers, to
I have read the fraud notice applicable to my state, if a	iny, on the reverse side of	this form.
Signature of Proposed Insured		Date

(your legal signature - do not print)

12-82-055(REV)

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and a denial of insurance benefits.

MARYLAND

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

ОНО

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

WASHINGTON

- 1. Please review and complete this form. If you make changes, please make them on both copies and initial your changes. Be sure to sign and date both copies and return one copy to us. Attach the other copy to your Policy.
- 2. Make a check or money order payable to Colonial Penn Life for the amount shown on your premium notice. If you are paying by credit card, we will automatically charge your premium to your credit card.

Questions? Call us Toll-Free ########### for Assistance

APPLICATION For ###################################	Source Code: ####################################
Colonial Penn Life Insurance Company, Philadelphia, PA 19181	#########
Proposed Insured:	
Date of Birth: Age: Se	x: <u>#####</u>
Area Code/Phone: ########## Area Code/Phone:	
Proposed Owner: ############# Relationship: ##	
	
City, State, Zip:	<u></u>
Amount of Life Insurance: ####################################	
I wish to pay: ####################################	nclosed: #########
1. Statement of Health Answer each of the following questions "Yes condition(s) which apply.	or "No." If "Yes" CIRCLE the
A. Are you currently: (1) using assistance from another person to perform	our daily activities
A. Are you currently: (1) using assistance from another person to perform such as dressing, eating or walking; (2) using a walker, wheelchair or	motorized mobility
device; (3) using supplemental oxygen; (4) confined to a hospital, assist facility, or correctional institution?	ed care or nursing ()Yes (X)No
B. Have you been advised to have in-patient surgery which has not yet been	performed? ()Yes (X)No
C. In the past three years, have you had, been diagnosed by a member profession with, or received treatment for (1) chronic obstructive	er of the medical pulmonary disease
(COPD), emphysema or chronic bronchitis: (2) chronic liver disease	(including chronic
hepatitis), cirrhosis of the liver; (3) chronic kidney disease (not including heart attack (myocardial infarction), cardiac arrhythmia, or congestive	heart failure: (5)
thrombosis or embolism (blood clots)?	()Yes (X)No
D. In the past five years, have you had, been diagnosed by a member of the with, or received treatment for (1) stroke, transient ischemic attack (TIA)	medical profession , or heart or blood
with, or received treatment for (1) stroke, transient ischemic attack (TIA) vessel surgery; (2) dementia, Alzheimer's disease, or ALS (amyotrophic la	iteral sclerosis); (3)
diabetes; (4) cancer (not including basal cell skin cancer); (5) Immunodeficiency Syndrome), infection with HIV (Human Immunode	AIDS (Acquired ficiency Virus), or
diabetes; (4) cancer (not including basal cell skin cancer); (5) Immunodeficiency Syndrome), infection with HIV (Human Immunode other immune system disorder; (6) mental or nervous system disorder treatment or confinement in an institution was recommended or complete	or which inpatient
drug abuse, or has treatment been recommended?	eted; (7) alcohol or ()Yes (X)No
E. Physician's Name (Please Print) Ph	
Physician's Address	
2. Beneficiary Designation (will be divided equally unless noted otherwise)	
Beneficiary Name (Please Print) Relationship to You % Share Beneficiary Name (Please Print) Relationship to You % Share	
3. Is this insurance intended to replace or change any existing life insurance	or annuity plan? ()Yes (X)No
Name of Insurance Company Plan of Insurance	Amount of Insurance
I have read the questions and my answers are true to the best of my know	edge and belief. I understand that
this application shall form a part of any policy issued and that, within statement or answer can be used to contest the policy as of its effective date	e or to deny a claim. I understand
and agree that no life insurance is in effect as a result of this ap	plication unless this application
is approved by the Company, a policy is issued during my lifetime according to medical information provided in this application, and the pro-	and my continued insurability, emium has been paid. The policy
will be effective on the Policy Date shown on the Policy Schedule.	
I authorize any licensed physician, medical practitioner, hospital, clinic or facility, insurance company, or MIB, Inc., or any other organization, institution	other medical or medically related
or knowledge of me or my health, to give to Colonial Penn Life Insurance	Company and its underwriters or
reinsurers any such information. I understand such information will be used insurance. A reproduction of this authorization shall be as valid as the origin	to determine my eligibility for this
for a period of 24 months from the date signed. I understand that unrepresentative have a right to receive a copy of this authorization. I authorization	pon request, I or an authorized
representative have a right to receive a copy of this authorization. I authorito make a brief report of my personal health information to MIB. I have	ze the Company, or its reinsurers,
Applicant. I have read the fraud notice applicable to my state, if any, on the	reverse side of this form.
Signature of Proposed Insured(your legal signature - do not print)	Date
Signature of Proposed Owner	Date
(if other than Insured) (your legal signature - do not print)	

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and a denial of insurance benefits.

MARYLAND

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

ОНО

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

WASHINGTON

- 1. Please review and complete this form. If you make changes, please make them on both copies and initial your changes. Be sure to sign and date both copies and return one copy to us. Attach the other copy to your Policy.
- 2. Make a check or money order payable to Colonial Penn Life for the amount shown on your premium notice. If you are paying by credit card, we will automatically charge your premium to your credit card.

Questions? Call us Toll-Free #	######################################	tance					
APPLICATION For ##################		Source Code: ####################################					
Colonial Penn Life Insurance Company, Philade	lphia, PA 19181	#####################################					
Proposed Insured	E-Mail Address: !!!!!!!!!	!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!					
######################################	Date of Birth: ######						
######################################	Age: ##	Sex: ######					
Area Code/Phone: ####################################	Area Code/Phone:						
Amount of Life Insurance: ####################################	Amount of Accidental I Amount of premium pa	Death Protection: ######## yment enclosed: #########					
1. Statement of Health Answer each of the followir							
such as dressing, eating or walking; (2) using a valevice; (3) using supplemental oxygen; (4) confine facility, or correctional institution? B. Have you been advised to have in-patient surgery was C. In the past three years, have you had, been diagnose with, or received treatment for (1) chronic of emphysema or chronic bronchitis; (2) chronic list cirrhosis of the liver; (3) chronic kidney disease attack (myocardial infarction), cardiac arrhythmia, or embolism (blood clots)? D. In the past five years, have you had, been diagnose with, or received treatment for (1) stroke, transient vessel surgery; (2) dementia, Alzheimer's disease, of diabetes; (4) cancer (not including basal cel Immunodeficiency Syndrome), infection with HIV other immune system disorder; (6) mental or ner	 Statement of Health Answer each of the following questions "Yes" or "No." If "Yes" CIRCLE the condition(s) which apply. A. Are you currently: (1) using assistance from another person to perform your daily activities such as dressing, eating or walking; (2) using a walker, wheelchair or motorized mobility device; (3) using supplemental oxygen; (4) confined to a hospital, assisted care or nursing facility, or correctional institution?						
2. Beneficiary Designation (will be divided equally u	nless noted otherwise)						
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!	111111111111111111111111111111111111111	!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!					
Beneficiary Name (Please Print) Relationship to You % Share							
3. Is this insurance intended to replace or change any e	existing life insurance or a	nnuity plan? () Yes (X) No					
Name of Insurance Company Plan of Insura	ance	Amount of Insurance					
I have read the questions and my answers are true to application shall form a part of any policy issued an answer can be used to contest the policy as of its effect no life insurance is in effect as a result of this applicand a policy is issued during my lifetime and my provided in this application. In addition, no life insuits in effect unless the appropriate premium has been Policy Date shown on the Policy Schedule. If I elected benefit will be effective on the Rider Effective Date sh I authorize any licensed physician, medical practition facility, insurance company, or MIB, Inc., or any other knowledge of me or my health to give to Colonia	d that, within the contestive date or to deny a classifier unless this applicate continued insurability, arrance or, if elected, addit n paid. The life insurance additional accidental dear own on the rider attached ner, hospital, clinic or ot	table period, a false statement or im. I understand and agree that tion is approved by the Company ccording to medical information ional accidental death protection, e benefit will be effective on the th protection, the accidental death I to the policy. Ther medical or medically related					

		utution or person, that has any records or
		rance Company and its underwriters or
reinsurers any such information.	I understand such information will be	e used to determine my eligibility for this
insurance. A reproduction of the	is authorization shall be as valid as the	e original. The authorization will be valid
for a period of 24 months fr	om the date signed. I understand	that upon request, I or an authorized
representative have a right to rec	eive a copy of this authorization. I au	thorize the Company, or its reinsurers, to
make a brief report of my person	nal health information to MIB. I have i	received and read the Notice to Applicant.
I have read the fraud notice appl	icable to my state, if any, on the reverse	e side of this form.
Signature of Proposed Insured _	•	Date
•	(your legal signature - do not print)	
12-82-057(REV)		
		/////////////////////////////////////

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and a denial of insurance benefits.

MARYLAND

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

ОНО

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

WASHINGTON

- 1. Please review and complete this form. If you make changes, please make them on both copies and initial your changes. Be sure to sign and date both copies and return one copy to us. Attach the other copy to your Policy.
- 2. Make a check or money order payable to Colonial Penn Life for the amount shown on your premium notice. If you are paying by credit card, we will automatically charge your premium to your credit card.

Questions? Call us Toll-Free ########### for Assistance

APPLICATION F	or <i>####################################</i>		Source Code: ####################################
Colonial Penn Life	Insurance Company, Philadelpl	hia, PA 19181	######################################
	/////////////////////////////////////		
Date of Birth:	####### Ag	e: <u>##</u> Se:	K: <u>######</u>
Area Code/Phone:		Area Code/Phone:	
=	#####################################		
Owner Address:	#####################################		
City, State, Zip:	<u>!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!</u>		
Area Code/Phone:		Area Code/Phone:	
Amount of Life In I wish to pay:	#####################################	Premium payment en	Death Protection: ####################################
1. Statement of Hea condition(s) which	lth Answer each of the follow	ing questions "Yes" o	or "No." If "Yes" CIRCLE the
A. Are you currently	: (1) using assistance from another	person to perform you	ar daily activities
such as dressing,	eating or walking; (2) using a wa	lker, wheelchair or mo	otorized mobility
device; (3) using	supplemental oxygen; (4) confined	to a hospital, assisted	care or nursing ()Yes (X)No
facility, or correcti	vised to have in-patient surgery which	ch has not vet been nert	
C. In the past three y	rears, have you had, been diagnosed	by a member of the m	
with, or received	d treatment for (1) chronic obs	structive pulmonary d	lisease (COPD),
emphysema or ch	pronic bronchitis; (2) chronic liver	r disease (including ch	ronic hepatitis),
cirrhosis of the li	iver; (3) chronic kidney disease (r l infarction), cardiac arrhythmia, or	ot including kidney st	iones); (4) heart
or embolism (bloo	d clots)?	congestive near randic	()Yes (X)No
D. In the past five ye	ears, have you had, been diagnosed	by a member of the m	edical profession
with, or received t	treatment for (1) stroke, transient is dementia, Alzheimer's disease, or	schemic attack (TIA), c	or heart or blood
vessel surgery; (2)	dementia, Alzheimer's disease, or neer (not including basal cell	ALS (amyotrophic late	ral sclerosis); (3)
Immunodeficiency	Syndrome), infection with HIV	(Human Immunodefic	iency Virus), or
other immune sys	stem disorder; (6) mental or nervo	us system disorder for	which inpatient
treatment or conf	inement in an institution was reco	mmended or completed	d; (7) alcohol or
	treatment been recommended?		()Yes (X)No
E. Physician's Name ((Please Print)	Phone	e Number
Physician's Addres	S		
2. Beneficiary Design	nation (will be divided equally unle	ess noted otherwise)	!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!
Beneficiary Name (Please F	Print) Relationship to You % Share		Print) Relationship to You % Share
3. Is this insurance in	ntended to replace or change any ex	isting life insurance or a	
Name of Inguiance Company	Diox of Facus	0700	Amount of Inguina
Name of Insurance Company I have read the questi	Plan of Insur ions and my answers are true to		Amount of Insurance edge and belief. I understand that
this application shall	form a part of any policy iss	ued and that, within	the contestable period, a false
statement or answer co	an be used to contest the policy a	s of its effective date	or to deny a claim. I understand
	life insurance is in effect as Company and a policy is issued		
according to medical	information provided in this app	lication. In addition,	, no life insurance or, if elected,
additional accidental	death protection, is in effect unle	ess the appropriate pr	remium has been paid. The life
accidental death protec	tion, the accidental death benefit w	silowii oii the Policy	Schedule. If I elected additional Rider Effective Date shown on the
rider attached to the po	olicy.		
I authorize any licens	ed physician, medical practitioner	, hospital, clinic or or	ther medical or medically related
knowledge of me or m	v health, to give to Colonial Penn I	iganization, institution life Insurance Company	or person, that has any records or y and its underwriters or reinsurers
any such information.	I understand such information will	be used to determine	my eligibility for this insurance. A
reproduction of this au	thorization shall be as valid as the	original. The authorizat	tion will be valid for a period of 24
receive a copy of this	signed. I understand that upon reauthorization. I authorize the Co	mnany or its reinsure	ers, to make a brief report of my
personal health information	ation to MIB. I have received and r	ead the Notice to Appl	icant. I have read the fraud notice
applicable to my state,	if any, on the reverse side of this fo		Data
Signature of Proposed	(your legal signature -	do not print)	Date
Signature of Proposed	Owner		Date
(if other than Insured) 12-82-058(REV)	(your legal signature -	ao not print)	
· · · · ·			#######

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OKLAHOMA

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WASHINGTON

SERFF Tracking #:	State Tracking #:	Company Tracking #:	12-82-049(F)(REV)

Colonial Penn Life Insurance Company

State: Arkansas Filing Company:

TOI/Sub-TOI: L07I Individual Life - Whole/L07I.111 Single Premium - Single Life

Product Name: Individual Life Insurance

Project Name/Number: /

Supporting Document Schedules

		Item Status:	Status Date:	
Satisfied - Item:	Flesch Certification			
Comments:				
Attachment(s):				
ar recert.pdf				
		Item Status:	Status Date:	
Satisfied - Item:	Application			
Comments: See supporting doc and filing description				
		Item Status:	Status Date:	
Satisfied - Item:	Officers Certification			
Comments:				
Attachment(s):				
Officer's Cert.pdf				
		Item Status:	Status Date:	
Satisfied - Item:	Copy of Approval			
Comments:				
Attachment(s):				
ar copy of approval.pdf				



Colonial Penn Life Insurance Company • 399 Market Street • Philadelphia, Pennsylvania 19181

ARKANSAS READABILITY CERTIFICATION

This is to certify that the attached applications, Form Nos. 12-82-049(F)(REV), 12-82-050(F)(REV), 12-82-056(REV), 12-82-056(REV), 12-82-057(REV) and 12-82-058(REV) have achieved a Flesch Reading Ease Score of 57.2 and comply with the requirements of ACA 23-80-206.

Signature of Officer

Betty Hewes-Eddinger

Name of Officer

Assistant Secretary

Title

9/20/12

Date



Colonial Penn Life Insurance Company • 399 Market Street • Philadelphia, Pennsylvania 19181

OFFICER'S CERTIFICATION

I, Betty Hewes-Eddinger, Assistant Secretary of Colonial Penn Life Insurance Company, do hereby certify that the only change to the previously approved forms contained in this filing is the addition of the MIB language at the end of the second paragraph of the authorization section. No other changes have been made to the forms.

Buty Lemes Elding

SERFF Tracking Number:

BNLC-126676280

State:

Arkansas

Filing Company:

Colonial Penn Life Insurance Company

State Tracking Number:

46598

Company Tracking Number:

TOI:

L04I Individual Life - Term

Sub-TOI:

L04I,213 Specified Age or Duration -

Fixed/Indeterminate Premium - Single Life

Product Name:

Individual Term and Whole Life Applications

Project Name/Number:

SI Applications/12-82-049(F)

Filing at a Glance

Company: Colonial Penn Life Insurance Company

Product Name: Individual Term and Whole Life SERFF Tr Num: BNLC-126676280 State: Arkansas

Applications

TOI: L04I Individual Life - Term

SERFF Status: Closed-Approved-

State Tr Num: 46598

Sub-TOI: L04I.213 Specified Age or Duration - Co Tr Num:

State Status: Approved-Closed

Fixed/Indeterminate Premium - Single Life

Filing Type: Form

Co Status:

Reviewer(s): Linda Bird

Author: Karen Schussler

Disposition Date: 08/26/2010

Date Submitted: 08/25/2010

Disposition Status: Approved-

Status of Filing in Domicile: Pending

Explanation for Other Group Market Type:

Corresponding Filing Tracking Number:

State Status Changed: 08/26/2010

Created By: Karen Schussler

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Implementation Date Requested: On Approval

Implementation Date:

General Information

Project Name: SI Applications

Project Number: 12-82-049(F)

Requested Filing Mode: Review & Approval Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 08/26/2010

Company Status Changed:

Deemer Date:

Submitted By: Karen Schussler

Filing Description:

12-82-049(F) Application for Life Insurance

12-82-050(F) Application for Life Insurance with Accidental Death Rider

12-82-055 Application for Life Insurance

12-82-056 Application for Life Insurance

12-82-057 Application for Life Insurance with Accidental Death Rider

12-82-058 Application for Life Insurance with Accidental Death Rider